TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Texas Health of Dallas

Respondent Name
Texas Mutual Insurance

MFDR Tracking Number
M4-18-2221-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
February 26, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per the TDI/ DWC fee schedule this account qualifies for an Outlier payment..."

Amount in Dispute: $993.23

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "No additional payment is due for an OPPS outlier."

Response Submitted by: Texas Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 13, 2017	Outpatient Hospital Services	$993.23	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the acute care hospital fee guideline for outpatient services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers compensation jurisdictional fee schedule adjustment
   - 616 – This code has a status Q APC indicator and is packaged into other APC does that have been identified by CMS
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly

Issues

1. Is the requestor's position statement supported?
2. What is the recommended payment for the services in dispute?

Findings

1. The requestor states in their position statement, "…this account qualifies for an Outlier payment…"

   28 Texas Administrative Code §134.403 (f) states in pertinent part,

   > The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.
   >
   > (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
   >
   > (A) 200 percent;

   Medicare's Outpatient Prospective Payment System (OPPS) assigns an Ambulatory Payment Classification (APC) for billed services based on procedure codes and supporting documentation. The APC determines the payment rate. Hospitals may be paid for more than one APC per encounter. Payment for ancillary items and for services without procedure codes is packaged into the APC payment. The Centers for Medicare and Medicaid Services (CMS) publishes quarterly lists of APC rates in the OPPS final rules, available from www.cms.gov.

   Reimbursement for the disputed services is calculated as follows:

   - Procedure code 86850 has status indicator Q1, denoting STV-packaged codes; reimbursement is packaged with payment for any code with status indicator S, T or V.
   - Procedure code 36415 has status indicator Q4, denoting packaged labs; reimbursement is included with payment for the primary services.
   - Procedure code G0480 has status indicator Q4, denoting packaged labs; reimbursement is included with payment for the primary services.
   - Procedure code 80053 has status indicator Q4, denoting packaged labs; reimbursement is included with payment for the primary services.
   - Procedure code 85610 has status indicator Q4, denoting packaged labs; reimbursement is included with payment for the primary services.
   - Procedure code 85025 has status indicator Q4, denoting packaged labs; reimbursement is included with payment for the primary services.
   - Procedure code 86901 has status indicator Q1, denoting STV-packaged codes; reimbursement is packaged with payment for any code with status indicator S, T or V.
   - Procedure code 86900 has status indicator Q1, denoting STV-packaged codes; reimbursement is packaged with payment for any code with status indicator S, T or V.
   - Procedure code 73110 has status indicator Q1, denoting STV-packaged codes; reimbursement is packaged with payment for any code with status indicator S, T or V.
   - Procedure code 73090 has status indicator Q1, denoting STV-packaged codes; reimbursement is packaged with payment for any code with status indicator S, T or V.
   - Procedure code 73070 has status indicator Q1, denoting STV-packaged codes; reimbursement is packaged with payment for any code with status indicator S, T or V.
   - Procedure code 73030 has status indicator Q1, denoting STV-packaged codes; reimbursement is packaged with payment for any code with status indicator S, T or V.

- Procedure code 74177 has status indicator Q3, denoting packaged codes paid through a composite APC (if OPPS criteria are met). This code is assigned to composite APC 8007. The payment for composite services is calculated below.
- Procedure code 72125 has status indicator Q3, denoting packaged codes paid through a composite APC (if OPPS criteria are met). This code is assigned to composite APC 8007. The payment for composite services is calculated below.
- Procedure code 70450 has status indicator Q3, denoting packaged codes paid through a composite APC (if OPPS criteria are met). This code is assigned to composite APC 8007. The payment for composite services is calculated below.
- Procedure code 71260 has status indicator Q3, denoting packaged codes paid through a composite APC (if OPPS criteria are met). This code is assigned to composite APC 8007. The payment for composite services is calculated below.
- Procedure code 99285 has status indicator J2, denoting hospital, clinic or emergency visits subject to comprehensive packaging if 8 or more hours observation billed. Review of the submitted bill finds the comprehensive packaging criteria has not been met. This code is assigned APC 5025. The OPPS Addendum A rate is $488.74. This is multiplied by 60% for an unadjusted labor-related amount of $293.24, which is multiplied by the facility wage index of 0.9794 for an adjusted labor amount of $287.20. The non-labor related portion is 40% of the APC rate, or $195.50. The sum of the labor and non-labor portions is $482.70. **The cost of services does not exceed the fixed-dollar threshold of $3,825. The outlier payment is $0.** The Medicare facility specific amount of $482.70 is multiplied by 200% for a MAR of $965.40.
- Procedure code 96374 has status indicator S, denoting significant outpatient procedures paid by APC, not subject to reduction. This code is assigned APC 5693. The OPPS Addendum A rate is $179.77. This is multiplied by 60% for an unadjusted labor-related amount of $107.86, which is multiplied by the facility wage index of 0.9794 for an adjusted labor amount of $105.64. The non-labor related portion is 40% of the APC rate, or $71.91. The sum of the labor and non-labor portions is $177.55. **The cost of services does not exceed the fixed-dollar threshold of $3,825. The outlier payment is $0.** The Medicare facility specific amount of $177.55 is multiplied by 200% for a MAR of $355.10.
- Procedure code Q9967 has status indicator N, included in the payment for the primary services.
- Procedure code J3010 has status indicator N, included in the payment for the primary services.
- Procedure codes 74177, 72125, 70450, and 71260 have status indicator Q3, denoting packaged codes paid through a composite APC. These codes are assigned APC 8006. The OPPS Addendum A rate is $489.37. This is multiplied by 60% for an unadjusted labor-related amount of $293.62, which is multiplied by the facility wage index of 0.9794 for an adjusted labor amount of $287.57. The non-labor related portion is 40% of the APC rate, or $195.75. The sum of the labor and non-labor portions is $483.32. **The cost of services does not exceed the fixed-dollar threshold of $3,825. The outlier payment is $0.** The Medicare facility specific amount of $483.32 is multiplied by 200% for a MAR of $966.64.

2. The total recommended reimbursement for the disputed services is $2,287.14. The insurance carrier has paid $2,932.27 leaving an amount due to the requestor of $0.00. Additional payment is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has / has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		March 15, 2018
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.